SURA/Jefferson Science Associates: Brief summary of benefit changes and cost effective April 1, 2010 - ACTIVE EMPLOYEES

This is only a brief summary of benefit changes. It is very important that you review the enrollment materials for more specific details of your benefits.

		Current Benefits	Benefits as of 4/1/10
BlueCare 200 Plan (Anthem BCBS)	Calendar Year Deductible	$100 / Individual $200 / Family	$200 / Individual $400 / Family
	Mail Order Prescription Drug Plan Copays (90-Day Supply)	Tier 1: $16 Tier 2: $30 Tier 3: $60	Tier 1: $8 Tier 2: $30 Tier 3: $90
	Monthly Contribution		
	Employee Only Employee + Child Employee + Spouse Employee + Family	$172.30 $250.20 $360.30 $471.40	$187.80 $272.70 $392.70 $513.80
HealthKeepers HMO 15 Plan (Anthem BCBS)	Home Health Care	No charge	$35 per calendar month
	Skilled Nursing Care	No charge Maximum of 100 Days Per Condition	20% coinsurance Maximum of 100 Days Per Admission
	Ambulance Services (Ground & Air)	No charge	$100 Copayment
	Mail Order Prescription Drug Plan Copays (90-Day Supply)	Tier 1: $16 Tier 2: $30 Tier 3: $60	Tier 1: $8 Tier 2: $30 Tier 3: $90
	Monthly Contribution		
	Employee Only Employee + Child Employee + Spouse Employee + Family	$98.00 $142.00 $205.20 $268.80	$106.80 $154.80 $223.70 $292.90
Dental (Delta Dental)		There are no benefit changes for 4/1/2010	
	Monthly Contribution		
	Employee Only Employee + Child Employee + Spouse Employee + Family	$11.00 $18.60 $18.60 $29.60	$11.40 $19.20 $19.20 $30.70

		Current Benefits	Benefits as of 4/1/10
Keycare 15 Plus PPO Plan (Anthem BCBS)	Home Health Care (90 visits per CY)	No charge	20% coinsurance
	Mail Order Prescription Drug Plan Copays (90-Day Supply)	Tier 1: $16 Tier 2: $30 Tier 3: $60	Tier 1: $8 Tier 2: $30 Tier 3: $90
	Monthly Contribution		
	Employee Only Employee + Child Employee + Spouse Employee + Family	$119.20 $172.30 $249.10 $325.80	$129.90 $187.80 $271.50 $355.10
Optima HMO 3500 Plan (Sentara)	Advanced Imaging (MRI, MRA, PET, CT, and CTA Scans)	$100 copay	$150 copay
	Emergency Room (Facility Copay)	$100 copay	$200 copay
	Non-Biologically Based Mental Health Visits	Copayments paid for these services do not count toward the member's calendar year maximum out-of-pocket amount	Copayments paid for these services count toward the member's calendar year maximum out-of-pocket amount
	Pre-authorized Injectable and Infused Medications, Biologics, and IV Therapy Medications (Excluding Chemotherapy, Allergy Injections or Serum)	The member pays the applicable copayment (based on the setting) when these medications are provided in the physician's office, an outpatient facility, or a member's home	The member pays 20% coinsurance plus the applicable copayment (based on the setting) when these medications are provided in the physician's office, an outpatient facility, or a member's home
	Routine Colonoscopy Procedures	Members pay an additional charge (based on the setting) if a diagnostic procedure is performed during a routine colonoscopy screening	Screenings for routine colonoscopy procedures will be covered at the preventive care benefit level even if polyps are discovered or a biopsy is needed during the same procedure
	Routine Vision Services	Eye exam and covered vision materials every 24 months	Eye exam and covered vision materials every 12 months
	Monthly Contribution		
	Employee Only Employee + Child Employee + Spouse Employee + Family	$88.80 $128.90 $186.30 $244.10	$93.70 $136.00 $196.50 $257.50